W W Ely

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CASES OF TALIPES, OR CLUB-FOOT.

[Read before the Boston Society for Medical Improvement, December 28th, 1857, and communicated for the Boston Medical and Surgical Journal.]

BY BUCKMINSTER BROWN, M.D. BOSTON.

Some time since, the original plaster casts of a case of talipes varus, in its severest grade, of which one of these on the table is a copy, were shown to this Society, and at the same time the young man, whose feet at a former period of his life they represented, was present for examination.

At the suggestion of Dr. J. B. S. Jackson, new models have been taken, to be placed in the Cabinet. The case was brought forward at that time, not because the success which had attended the treatment was unusual, but simply as an instance in which had been performed one of the earliest operations for talipes in the United States, and the only one where an opportunity had offered for tracing the history of what had been an aggravated case of varus, after the lapse of such a number of years.

The case excited considerable interest in the Society, and was regarded by many as a remarkable example of a complete cure of club-feet. This, however, was not the light in which it was viewed by Dr. Brown, Sen., who operated in the case, or by myself. We considered it of great interest as presenting an instance, some eleven or twelve years after restoration, in which the strength of re-united or new tendon had been rigorously tested, and where the perfection and permanence of the cure was strikingly exemplified. It was originally double congenital varus in its worst degree. The smallest of the casts upon the table, marked No. 1, is an accurate model of both feet previous to treatment. They were precisely alike. (See figure 1.) Locomotion was effected on the anterior extremity of the os calcis and the proper superior surface of the os cuboides, or, in other words, upon the top of the foot. Upon examining the cast it will also be remarked as one of the most striking peculiarities; the longitudinal doubling, or complete folding inward of the soles, forming a deep groove, by which the great and little toes are brought almost in contact; and like-wise will be observed the prominence of the round head of the astragalus upon the dorsum of each foot. The large cast, No. 2, is the same foot taken twelve years after. (See figure 2.) The subject was examined by the members of the Society at that time, and the faithfulness of the artists' representation* can be attested by all who were then present. The restoration was as complete as when he was first lost sight of by the surgeon. The feet were perfect, both in form and in freedom of action. They had become fully developed in bone and muscle, and somewhat exceeded in size an average foot. The intervening years had been passed partly at sea, performing duty as a sailor before the mast; and whether on land or sea, he stated that he had never experienced any inconvenience from his feet, and in appearance there certainly was no trace of the former distortion. He has more recently become mate of a ship.

Figure 1.

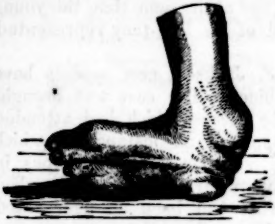
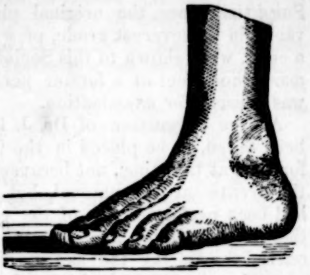


Figure 2.



Since these casts were taken (1854), old cases of cured feet have reported themselves more frequently. Among others, I would refer to a young man who had been treated when a child for single varus, but who came to Boston in 1841 with his difficulty still unrelieved. In this case the tendo-Achillis was divided twice; the tibialis anticus, the tibialis posticus and the flexor longus pollicis each, once. The foot was completely cured. He has recently visited Boston, thirteen years having elapsed since his former visit. The foot which had been operated upon could not be distinguished from the one which had been always perfect. All the natural movements of the foot—flexion and extension, abduction and adduction—were freely and actively performed. He had finished his education as an engineer, and had been engaged in his profession for a year or more. During the last eight months of the year 1856, he walked ten hundred and ninety miles, carrying his apparatus and wheeling his odometer. In a letter recently received from him, he says: "In respect to my foot, I can walk twenty-five miles a day, and while at work I would travel from twelve to twenty miles each day."

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* Messrs. Chicci & Garey were the artists employed.

The cast marked No. 3 (see figure 3) is the model of the left foot of a lad 13 years of age, who was under treatment some years since. A more formidable case of distortion can hardly be imagined. If it were not identified by the toes, we could scarcely recognize it as the representation of a human foot. The metatarsus was doubled and twisted upon the tarsus in a most remarkable manner, forming, at the point of union, a sharp prominent ridge upon the top and side of the foot. The astragalus was luxated upward and outward, and very much diminished in size. The atrophy of this bone produced one of the greatest difficulties with which we had to contend in the treatment. In the process of cure, as the foot advanced toward its normal position at a right angle with the leg, it was almost impossible to retain the astragalus in its proper situation. It constantly slipped forward, tending to completely defeat the successful issue of the case. The toes were flattened backward to such an extent as to be partially in contact with the dorsum of the foot, the little toe being pressed back against the top of the metatarsal bone of the fourth toe. There was, in addition, a contraction of the left leg at an obtuse angle with the thigh.

The cast next to this, marked 4 (figure 4), is the same foot after treatment. It will be observed that they are moulded with great accuracy, the one last taken exhibiting the wrinkles in the skin where it had formerly been stretched over the projecting astragalus and tarso-metatarsal prominences. It will also be seen that this does not represent a foot which is in all respects perfectly formed. When compared with its previous state, however, the improvement may be considered as being at least equal to the anticipations of the most sanguine.

Figure 3.

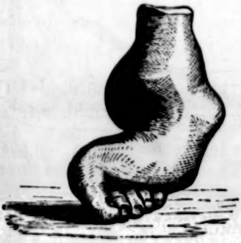
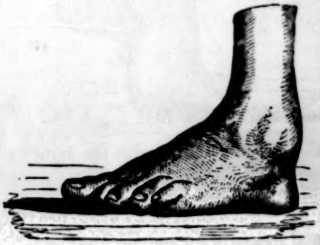


Figure 4.



It may be stated that the pencil sketches of the casts from which the annexed engravings were copied, were drawn with great exactness, and for truth of detail and finished execution can scarcely be excelled.

In the course of the treatment there were four sections of the tendo-Achillis. The union of this tendon advanced more rapidly than the foot could be proportionably straightened, and only a limited increased length of tendon could be acquired before firm union took place, presenting, after a short time, an unyielding obstacle to further progress. Re-division, therefore, became requisite to render continued extension possible.

Experiments upon animals, combined with previous experience, should be our guide in difficult and extraordinary cases. The former prove that divided tendon is re-united in about three weeks by a firm fibrous tissue, presenting considerable force of resistance, and that in five or six weeks it is perfectly continuous and inelastic. Still later, it becomes more solid than the original tendon.

The other parts divided in this case were the tibialis anticus, the adductor pollicis, the latter twice, the flexor longus pollicis, and some fasciculi of the plantar fascia; also the semitendinosus, the semimembranosus and the biceps.

The treatment resulted in a complete restoration of the leg, and the foot is now, I have been informed, in a more perfect condition than is represented by the cast or the engraving.

The third pair of casts (figures 5 and 6) represent a case of equino-varus in which the patient walked upon the extremities of the metatarsal bones. The toes were pressed back, the metatarsus flexed and rotated upon the tarsus; the astragalus, as may be distinctly seen upon the model, was thrown out and projected upon the dorsum pedis, with the bones of the leg resting upon its posterior portion and upon the os calcis. The heel was elevated three and half inches. The patient was a boy 11 years of age. The foot was discovered to be misshaped as soon as he began to walk, and was probably congenital equinus, converted by pressure in walking into equino-varus. He came to Boston in September, 1847, and consulted Dr. Inches, who referred him to me. The parts divided were an adventitious ligament, broad, thick, and unyielding, which extended from the os calcis to the base of the great and

Figure 5.

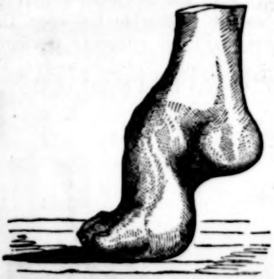
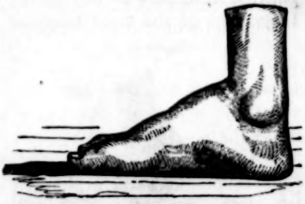


Figure 6.



second toes; this was formed, probably, from the plantar fascia—the flexor longus pollicis and the tendo-Achillis.

This case was remarkable not only for the severity of the distortion, but also, considering the age of the patient, for the unusual rapidity of the cure. The operation was done on the 22d of September, 1847. September 30th the toes were straight, the foot at a right angle with the leg, and the patient, for the first time in his life, could place his heel upon the floor. The plaster cast numbered 6 (figure 6) is the same foot after treatment.

There is also upon the table for examination the daguerreotype of a child, 4 years of age, from Cohoes, New York.

This portrait was recently forwarded in answer to inquiries concerning the state of the feet. They had previously been operated upon by a distinguished surgeon of Albany, but were a severe form of double varus when brought to Boston two years since. It gives the full length figure of the little boy, and the unerring impress of solar light represents the feet as perfect. An artistic response of this kind is certainly as graphic and satisfactory a reply to his queries as the physician or surgeon could desire.

[Dr. WARREN remarked that he had been in a position to see a great number of the cases operated upon by Dr. Brown, and also after treatment, and that he had truly been surprised at the perfection of the cures and the great care and unwearied attention by which this favorable result was accomplished. He thought it very important that all of this class of cases should be placed in the hands of some one or two of the profession who had given great attention to the subject, and who had the necessary variety of apparatus by which alone a successful issue could be obtained. He said that various cases were brought to the Hospital—poor patients—upon whom they felt obliged to operate, and that in a short time sores would appear upon the feet, and various other drawbacks would occur, and before the patients left the institution the surgeons were heartily sick of the cases.

Dr. J. HOMANS remarked that he fully concurred with Dr. Warren respecting the treatment of cases of this description by Dr. Brown.

Dr. H. having been a member of the Board of Trustees of the Boston Orthopœdic Association, had opportunities to witness the practice of the Drs. Brown. The results of these cases were generally successful, some of them surprisingly so. He had seen several of their cases in private practice, some very unpromising, attended with like success. It gave him pleasure to be thus able to testify to Dr. Brown's skill, and to the zeal and perseverance which he so constantly manifests. When we consider that this class of cases do not abound, it is desirable that they should be treated by a few only, whose experience and skill will be thereby increased, the necessary apparatus in all its variety be constantly on hand, and thereby the best results attained.—SECRETARY.]

THE EPIDEMIC YELLOW FEVER OF 1856, AT BAY RIDGE AND FORT HAMILTON, L. I., WITH ITS PREDISPOSING AND EXCITING CAUSES.

BY C. D. GRISWOLD, M.D.

[Communicated for the Boston Medical and Surgical Journal.]

A TRUE history of the epidemic of 1856 has never yet been published, and probably never will be; but in place of a full treatise on the subject, I offer the following familiarly written sketch, which is accurate so far as it goes, and embraces the leading points of interest.

The health laws of New York are among the most important for the protection of the people and their commercial interests. Of these there are two departments—viz., such as provide protection against *local* causes of disease, and such as are designed to protect the city against the *importation* of disease from distant places. The last come under the head of quarantine regulations.

Yellow Fever is a disease native only of hot climates, and therefore cannot prevail in New York or vicinity, except that the seeds are imported and planted under circumstances favorable to its development. One of these conditions consists in a temperature above 80 degrees Fahr. Observers have noticed that the disease, or rather the cause of the disease, has been developed most rapidly where the conditions were best adapted to produce mould, viz., heat and moisture in a confined atmosphere. There must be, then, a predisposing and an exciting cause of yellow fever in our climate—the predisposing must be local, while the exciting cause must come from a distance.

A ship, receiving cargo at Havana during the prevalence of yellow fever there, takes on board, in every package of goods, the malignant poison. The hatches are closed and the vessel sails for New York. During the voyage, the malarial poison within the hold becomes intensified by the heat, moisture and confined atmosphere, to such a degree that it is readily engrafted upon the shore where it is allowed to escape, if the conditions are only favorable to its propagation as above stated.

Yellow fever belongs to the class of *malarial* fevers, *i. e.* diseases produced by exhalations from the surface of the earth. Of these, fever and ague is the simplest type; remittent, or bilious fever is the next in severity; typhoid is still more aggravated, and is the nearest in its approach to yellow fever. Fever and ague runs its course in successive chills, followed with fever and perspiration; remittent fever runs its course with a less number of chills; typhoid fever is seldom attended with more than two or three chills, when the fever assumes a continued and pernicious form. Yellow fever has but one chill, which is followed by a malignant grade of fever, and terminates in death or convalescence usually on the fourth day. Now from the above, it will readily be understood that yellow fever is most likely to take root and be fostered in a district where the lighter forms of malarial fevers prevail. This is almost an invariable law in the communication and spread of the disease. This view of the subject reveals the predisposing cause of yellow fever, and without which there can be *no communication* of this scourge in our northern climate.

For three years previous to 1856, malarial fevers had prevailed to a considerable extent at Fort Hamilton and Bay Ridge. In 1853, the type was intermittent, of a mild form, and commenced as early as April. In 1854 there were a good many cases of bilious remittent fever in summer and autumn, and not so much intermittent. In 1855 there was little intermittent fever, but in the fall a number of fatal cases of typhoid fever occurred. A man by the name of Arthur McKeever (who lived with his family of a wife and three children in a low situation with stagnant water around his house), had marked symptoms of yellow fever. He was a coppersmith, and worked in Cherry street, New York, before and after his illness. From the yellowness of his skin, the vomiting of dark blood, delirium, and at the same time his exhibiting much strength and restlessness, I was led to remark that his case was much like yellow fever at the time. The wife and children all had aggravated intermittent. Once, on a professional visit, I found them without a fire in the house, or food, from inability to make the one, or prepare the other. These necessities were soon supplied by the neighbors, on their case being made known. All the members of this family recovered. In another family I knew of four cases of fever, of which the three first became typhoid, and the patients died. I was called to the third case in the last stages, and attended the fourth from the first attack.

From the above, it will be seen that for three successive years previous to the yellow fever season, the type of prevailing fevers became more and more severe, and approached in character to a close alliance with the disease of 1856. In May, of that year, during one week, I knew of three fatal cases of what I regarded at the time as malignant intermittent. The cases were poor children, and attracted little attention, but the severe type of disease, and the previous three years' experience, warned me that we were on the eve of an epidemic, and I so stated at the time; but the usual repugnance to predictions of evil, and the fact that a mention of any form of fever in the district was a subject under *taboo*, caused all such remarks to be treated lightly.

Over the district known under the name of Bay Ridge, Yellow Hook and Fort Hamilton, in the town of New Utrecht, there are scattered a great number of stagnant ponds or sunken pools of water, which dry away during the summer season, depending upon the amount of rain that falls, and these give off the malaria which is the cause of the fevers. If they become dry in the spring, intermittent fever is produced; if in mid-summer or fall, remittent or bilious fever is the result.

During the month of July, 1856, there was about two weeks of extremely hot weather, and most of this time the thermometer ranged above 80°. This high temperature caused a rapid evaporation of surface-water and exhalation of malaria; cases of bilious fever began to occur, but without attracting any special attention until yellow fever began to be developed. The fleet of ships lying at Quarantine, directly opposite where the first cases occurred, drew public attention to them as the cause, in which the local or predisposing cause was entirely lost sight of. The communication of the yellow-fever poison or malaria was unquestionably from bedding and refuse matter thrown from infected vessels, and allowed to float or be hauled upon our shore to lie and dry in the hot sun. Being thus brought into contact with an atmosphere already tainted or impregnated with malaria of a milder grade, the virulent poison of yellow fever became readily engrafted, and thus changed the type from remittent or bilious, to that of yellow fever. In this theory we have a full explanation of the fact, that with very few exceptions the cases were those of simple remittent fever at the beginning, and, unlike yellow fever, would often run on for a week or ten days without anything to indicate the result, viz., a sudden change to yellow fever and death. We have also an explanation (and an important lesson) in these views, of the fact that the cases of fever which were treated that season by the prompt administration of quinine, almost invariably recovered; and moreover, that those who took quinine as a prophylactic were invariably exempt from the disease.

Of thirty-six cases of fever, for which I prescribed between the 25th of July and the 26th of August, but four were fatal. The *first* of these was a Mr. P——l, who was forsaken by his watcher at a critical period, and remained for ten hours without medicine. The *second* was a female servant, who vomited all the remedies administered during the first day, and died on the sixth. The *third* and *fourth* were a gentleman and his wife, who were prejudiced against the use of quinine, and neither took it as a preventive nor after the attack, until a consulting physician advised it. The last three cases occurred in the same house, and the last two were yellow fever from the first. The house was old and badly ventilated, and around the premises the grounds had been recently graded, and a superficial pond of stagnant water was situated near by. The thirty-two cases of fever which recovered were by no means all yellow fever; but there is every probability that they would have been, had not the disease been promptly arrested at the first remission by the use of from twenty to sixty grains of quinine.* Seven of these cases occurred in a house opposite Quarantine, directly opposite the shore, where the first of the four deaths referred to above, occurred, and one other patient recovered after turning yellow, and being pronounced nearly in a hopeless condition by a Quarantine physician. Three other cases occurred at Bay Ridge in a house where one had died of unmistakable yellow fever but a few days previously. I saw this patient just before death, and afterward prescribed for the three other members of the family who recovered—indeed they did not take to their beds, as the disease was arrested after the first paroxysm or symptom of attack. It is not, of course, to be expected that persons unacquainted with medicine would realize the cases thus arrested to be an attack of a disease that would likely prove fatal in four days. This is especially so, inasmuch as yellow fever is a disease that seldom brings terror to the patient. Had these cases been pure yellow fever, the mortality would undoubtedly have been much greater. Without, however, the prompt administration of quinine at the onset, as recommended by Dr. Stone, of New Orleans, they would unquestionably have become so, as was the case in almost every instance in the practice of two physicians in the district, who opposed the use of this drug, and whose deaths from the disease, in company with their patients, has afforded the best possible testimony both of their honesty and error.

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* The formula I used in the administration of quinine was as follows: Sulph. quiniæ, grs. xl.; pulv. capsici, gr. v.; ext. taraxici, grs. xx. M. and divide into twenty pills. To arrest a fever, give two every two hours, during remission, until cinchonism is produced.

It is sometimes more difficult to contend with popular prejudice in a panic from an epidemic, than it is with the disease, and this was an instance of the kind in which, between the two, I came near being effectually extinguished.

One more topic connected with that epidemic, and I will have done. I refer to the fatal error so much permitted—the admitting of persons from healthy districts into infected houses. When a house becomes impregnated with the malaria which produces yellow fever, it is seldom eradicated in our climate until after a frost. Those who enter such houses breathe the poisoned atmosphere, and in that way take the disease, and not from the patient as is commonly supposed. The disease in a patient does not produce the same in another. A room filled with charcoal-gas (carbonic acid gas) will poison all who breathe it, and it is well known that persons found suffering in this way, must be immediately removed from such apartments, or else all will be poisoned who enter to take care of those already affected. The same rule holds in the occurrence of yellow fever in a house where there is reason to believe the disease was developed. From this view, it will be seen that the idea expressed by Mr. E. Meriam, of Brooklyn, was correct, in regard to the establishment of hospitals remote from the district where the disease prevails. Dr. Rush, who was great authority on this subject, advocated the plan of moving yellow fever patients in a carriage for the benefit of a change of air, and the moral effect upon the patient's mind.

The "Relief Hospital" at Fort Hamilton was established late in the season, and in direct violation of this rule. The building was directly on the shore, and half under an embankment; and, what is still more remarkable, the beds for it were brought from an infected hospital at Quarantine. I had two patients in this house, one of whom relapsed after it was converted into a hospital, and died. Cases of *fright*, or of any form of disease, would of course be likely to become yellow fever patients, under such circumstances.

In conclusion, I have only to say that the great means for our protection from yellow fever, is to provide against the local or *predisposing* causes of the disease, viz., the malaria which is eliminated from stagnant water, as in natural pools, sunken lots, and decayed docks. With these protections, a fleet of infected vessels might lie along side the piers of New York, and not communicate infection to be propagated in the city, and therefore communicate no disease except to those who breathe the atmosphere on shipboard. There might be evil enough communicated in this way, of course, to warrant protection against such an occurrence; but with such provisions, no instance of an epidemic like that which prevailed at Fort Hamilton and Bay Ridge could ever occur. It is due to the interests of society, that some legislative action should be taken upon the freedom exercised in and about New York, in promoting the causes of epidemic disease, by allowing stagnant ponds to be formed in street grading, or retaining them on grounds adjacent to the city, where they may have been formed by natural causes.

ON THE TRANSMISSION OF SYPHILITIC POISON FROM THE NURSE TO THE CHILD, AND FROM THE CHILD TO THE NURSE.

BY M. TROUSSEAU.

[Translated for the Boston Med. and Surg. Journal, from the *Gazette des Hôpitaux*.]

WHEN, on a former occasion, I was speaking on the important question of congenital syphilis, I intimated that at a future day I should call your attention to some very interesting clinical and medicolegal questions relating to the transmission of syphilis from the nurse to the child, and from the child to the nurse. Chance having brought into our little ward of lying-in women two young patients presenting unmistakable traces of original infection, I am unwilling to allow the occasion to pass without fulfilling my engagement.

In the first place, syphilis in the newly-born infant is essentially different, according as it is congenital or acquired; the symptoms and the prognosis are not the same. Death is the inevitable consequence of fœtal contamination, while cure is the general law of inoculation after birth.

Syphilis may be congenital in two ways; the mother being already infected at the moment of conception, or not becoming so until afterward. In the first case, the germ of disease is implanted in the diathesis, and syphilis is developed with the first beat of the heart; in the second, the evil is transmitted from the trunk to the bud, from the maternal bosom to the infant already formed.

Can the fœtus, of itself, while *in utero*, communicate syphilis to its mother? In other words, can an infant, whose father, formerly unfortunate, has ceased to exhibit conditions communicable directly from one parent to the other—can such an infant be to the mother the vehicle of venereal disease? A grave and difficult question is this—a case very embarrassing for the physician and advocate. How many elements conspire to prevent a satisfactory solution! Nevertheless, M. Ricord is disposed to adopt the affirmative view.

On deliberate reflection, it is no more easy to comprehend how the mother can, after having conceived, produce a change in the fruit of her womb, than to admit the possibility of infection of the mother by the fœtus. Only, if one of these facts is generally admitted, the other must remain somewhat doubtful.

Whatever may be its point of departure, the disease itself is none the less one and the same; M. Ricord, therefore, uniting these two varieties of congenital syphilis, has given them the same place in the nosological system.

With regard to acquired syphilis, we should first ask if it is transmissible to the child through the nurse's milk. This was formerly fully admitted. Hunter came, and he denied this proposition; his disciples, confirming their master's opinion, have not relinquished this view, and M. Ricord, who sustains with so much *éclat* the traditions of Hunter's school, has not met with a single authentic instance of the propagation of the venereal disease by the milk of the nurse. I say *by the milk*, for it would be supremely absurd to say that the child enjoyed a complete immunity, when the nurse bears on her nipple an infectious chancre.

How, then, is the disease transmitted? At the time of accouchement, when the head presents, the often repeated contact of the fingers of the accoucheur with the forehead or occiput of the child is of a nature to cause excoriations; suppose, under these circumstances, the woman to have chancres in the vagina, the pus which they secrete will infect the denuded surface, as it may in the same way inoculate the excoriated finger of the accoucheur or midwife. I hasten to add, that, of all the causes of syphilitic contamination to the infant, this is perhaps the least frequent, on account of the very rapid passage of the head through the vulva, the most common seat of specific lesions, and owing also to the peculiar protection arising from the sebaceous coating which covers the whole surface of the body.

I have seen at the Hospital Necker a little child four months old affected with chancres. Its mother, who had chancres and leucorrhœa, was in the habit of taking it, during the night, into her bed to nurse it. The child, when its cries were stilled, slept upon the belly of his mother, and as he had some slight excoriations, he became inoculated with the pus which flowed from the vulva.

There are nurses who, to obtain quiet and rest from the innocent creature which a confiding mother has trusted to them from the first, have recourse to profane manipulations and the most odious caresses. These women, of depraved instincts, lay upon the genital organs of the children, particularly those of little girls, the hands which they have soiled with their own impurity. The slightest excoriation very quickly gives access to the poison.

These examples must lead you to anticipate how essential it is to distinguish between congenital and acquired syphilis, and how important it is to follow step by step the development of the latter. In questions of such importance, legal medicine is every day called upon to enlighten justice, and often very sad discussions on this subject have wakened the echoes of our judgment halls. I say *very sad discussions*, for generally the resources of art and science have been obliged to give way to those of ignorance and prejudice. Apply yourselves, therefore, most diligently to a knowledge of those reefs to which some day the magistrate will consign your arguments, and convince yourselves thoroughly if you would convince others.

The child that syphilis infects after its birth, shows as distinct a chancre as an adult; the characters of the lesion are the same. Nevertheless, chancre in young children is extremely apt to take on the phagedenic form, which, as you know, postpones a little the constitutional symptoms; on the other hand, it may *furrow* the skin without producing infection. Hunter has said it. Ricord has repeated it. When the chancre is indurated—and it has this character more rarely in the child than the adult—syphilis is taken into the system. The constitutional diathesis having become established, it will follow its usual course, but taking on, in the case of young subjects, more of an exanthematous character.

Glandular enlargements accompany the infecting chancre; then, at the end of six weeks or two months, roseola appears, and later the pharynx and the nose are attacked. Finally, after a sufficient interval of time, the symptoms of the syphilitic cachexia are unmistakable.

Suppose you have offered to you a child a fortnight old affected with specific coryza—and this is the rule in hereditary syphilis: is this a case in which you have a right to affirm that the disease has been inherited from the mother? Most certainly, because coryza is one of the tardy phenomena of acquired syphilis.

Suppose another child is brought to you presenting mucous tubercles eight or ten days after birth, then at the end of a month hypertrophy of the liver—that positive sign of the venereal cachexia, a little later fissures of the lip and anus, and flattening of the nose: it would not be with you a question of probability, but it would be an absolute certainty that the case is one of congenital syphilis. You see how these differential signs of congenital or acquired syphilis can clear up a medico-legal question, and of what weight your evidence may be.

Can an infant affected with hereditary syphilis communicate the disease to its nurse? M. Ricord has denied that this is possible; but, a conscientious and very honest observer, he has recently modified his first opinion, and now thinks that such a transmission is possible. M. Ricord has observed, and all the Hunterian school have noticed with him, the great difficulty of communicating by inoculation the secondary symptoms of syphilis; but there exist now in science a sufficiently large number of facts which tend to compel the medical world to withdraw from its ancient belief. Answer, then, in the negative the question which we have proposed, and observe the very simple reasoning of the partisans of non-transmission: secondary accidents are not transmitted; now the syphilis which the child inherits is secondary, therefore it cannot infect the nurse. Observation would seem to confirm this method of reasoning. In fact, many infants very decidedly infected, leave the health of the women who nurse them entirely unaffected; but there are other facts which establish in a positive manner the possibility of this mode of contagion.

I come now to the recital of cases which thus establish the possibility of the communicability of the disease from the child to the nurse.

One of my professional brethren of Paris invited me to a consultation in the family of one of his patients. He informed me that the lady of the house was delivered, seven months before, of a healthy child, which became sick fourteen or fifteen days after birth, but without any manifestation of disease of the skin.

Toward the end of the second month and at the commencement of the third, a cutaneous affection supervened, of a nature to suggest the idea of syphilis. A little later, the nurse showed on her breast symptoms not at all encouraging; engorgement of the axillary glands of the corresponding side, an eruption of roseola over the whole surface of the body, and sore throat.

The physician inquired of the father of the child whether he had ever had syphilis; this he denied emphatically. To address a similar question to the mother was a thing next to impossible, so my friend was content with satisfying himself that she presented no traces of the disease. The nurse grew so much worse that it became necessary to confide the child to another woman. Three weeks after, the second nurse became affected in the breast. I was called in a short time after, and satisfied myself, by my own observation, of the existence of the most unmistakable signs of the diathesis. As for the child, it had a hypertrophy of the liver, as well as lesions of the skin and mouth.

Will you admit that both of these women had been previously infected? This would, to say the least, have been a singular coincidence; but the first of them was a married woman and had been remarkably healthy, as well as her husband, before she began to nurse the child. The second was a young girl from the country, confined four months previously, and having no knowledge of this disease. Nevertheless they were both infected, and both in the same way!

Such facts are very serious, and their number begins to be quite considerable. Secondary affections are, without doubt, transmitted with much more difficulty than primary ones, but they are, nevertheless, transmitted; and when communicated from the child to the nurse the contagion depends upon special conditions, on which I wish to fix for a moment your attention.

[To be continued.]

Bibliographical Notices.

Silver Sutures in Surgery;—The Anniversary Discourse before the New York Academy of Medicine. By J. Marion Sims, M.D., Surgeon to the Woman's Hospital. New York: Samuel S. & W. Wood. 1858. 8vo. pp. 79.

Dr. Sims is well known for his modifications of the operation for vesico-vaginal fistula. These modifications, which are very ingenious, and have contributed greatly toward the success of the treatment of that most distressing infirmity, are detailed in the American Journal of the Medical Sciences, January, 1852. They consist mainly in the prone position of the patient, and the employment of the "clamp suture" for keeping the edges of the wound in apposition, but the chief value of the description which Dr. Sims gives of his method of operating consists in the minuteness of the details which are so requisite for the success of this delicate operation. It was naturally to be expected that a surgeon who had done so much toward rendering this difficult operation more easy of performance, and whose own success had been so great, should meet with a corresponding reward in the praise of the profession, and the more solid recompense of a large and lucrative practice; and these have been liberally bestowed upon Dr. Sims. If his head has been completely turned by success, a large share of the blame must be borne by some of our New York brethren, whose extravagant and ridiculous laudations seem to have completely intoxicated him.

The subject of the pamphlet before us is "silver sutures in surgery," the employment of which Dr. Sims claims as his own discovery, but the discourse contains a history of all his latest improvements, and of the difficulties which he met with and overcame, in their accomplishment. The account would be highly interesting, if it were not for the extraordinary self-esteem, to use the mildest word, which the author displays throughout. We quote a few passages, which will convey an idea of the importance he attaches to his discovery. "I declare it as my honest and heartfelt conviction that the use of SILVER AS A SUTURE IS THE GREAT SURGICAL ACHIEVEMENT OF THE NINETEENTH CENTURY."—(The capitals are Dr. Sims's.) "After nearly four years of fruitless labor, silver wire was fortunately substituted for silk as a suture, and lo! a new era dawns upon surgery." "My language is nowise extravagant; and I shall yet live to see the day when the whole profession of the civilized world will accord to this simple discovery the high position of being the most important contribution as yet made to the surgery of the present century. The only thing at all comparable to it is etherization; and in practical results of permanent benefit, it [this] is absolutely contemptible when compared with those from the universal use of silver sutures in the broad domain of general surgery"!!

In the beginning of his discourse, Dr. Sims complains that Dr. Bozeman, of Montgomery, his partner and successor, attempted to rob him of the credit of his improvements, by making another, the "button suture," though appropriating the silver wire and perforated shot, "the only things of any real value whatever." We do not wish to enter into the merits of this complaint, but follow the author to his experiments with the "button" suture, which were so unsuccessful that he was convinced the "button" was a useless addendum. "The truth is," he says, "that the great success of these operations is due entirely to the silver wire." The clamps or leaden bars had failed, and so had the perforated shot, when employed with silken ligatures, and his conviction that the "button" was useless, led him to try the effect of a simple suture of silver wire. The experiment was successful, and Dr. Sims now in general uses no other means of uniting the surfaces. In introducing the wire, he prefers to pass silk ligatures first, and with these to draw the wires after. "They should be passed in, near the edge of the fistula, taking care to embrace the whole denuded surface, but not to penetrate the mucous lining of the bladder. They should, as a general rule, be about 3-16 of an inch apart, and each tied separately by twisting the two ends of the wire together, then cutting them off, and leaving the twisted ends at least half an inch long, to facilitate their removal." The wires need not be allowed to remain longer than the eighth day.

Besides the substitution of a simple suture of silver wire for more complicated contrivances, Dr. Sims has adopted other improvements on his original plan of proceeding. The speculum is altered, according to a drawing given in the pamphlet. Instead of a needle with a long shaft, or a needle-holder, he employs a simple pair of forceps, with serrated jaws, for holding a slender, straight needle with a curved point. The catheter is furnished with a lip for conducting the urine into a cup. A better diet is allowed, and a more comfortable position for the patient is adopted during the operation. In the majority of cases she may lie on the left side. "The thighs are to be flexed at about right angles with the pelvis, the right a little more than the left. The left arm is thrown behind, and the chest rotated forward, bringing the sternum quite closely in contact with the table, while the spine is fully extended, with the head resting on the parietal bone." Dr. Sims never employs anæsthetics in these operations, "because they are not painful enough to justify the trouble and risk attending their administration."

There is one idea of Dr. Sims's which we confess ourselves unable to comprehend; we mean that of the dilatation of the canal of the vagina by the atmospheric pressure. According to him, if the patient be placed on her hands and knees, and the sphincter vaginæ muscle be dilated, the air will rush in and distend the canal to its utmost extent, by its pressure of fifteen pounds to the square inch. If this phenomenon take place (we confess we have never tried the experiment), the explanation must be some other, we think, than that assigned by the author. The external atmosphere can exert no pressure unless there be a vacuum behind, and how a vacuum can be formed around the vagina, we cannot imagine. Even if the pelvis were very much raised, the position of the abdominal viscera, including the uterus, would be but little altered. They might fall slightly by their gravity, elongating the vagina, but this would create no vacuum, which, moreover, if it occurred, would be instantly filled by the contents of the abdomen, influenced by the same pressure on the abdominal walls.

If we have devoted rather a long space to the notice of this pamphlet, it is because the ingenuity and success of the author deserve praise. We wish we could say as much for his style. We hardly ever read any thing relating to scientific matters, written in worse taste. His absurd conceit and bombastic language will do almost as much to retard scientific medicine as his improvements in surgery have done to advance it.

The Massachusetts Register, containing a Record of the Government and Institutions of the State, and a Variety of Useful Information, for the Year 1858. *Serial Number Ninety-two.* By Adams, Sampson & Co. Boston: 1858. 8vo. Pp. 303.

This work is of great utility to every man of business, and the physician will find it both convenient and interesting, as it contains a complete statistical account of the profession in this State, arranged according to counties and towns, the irregular practitioners being designated. The following table, compiled from the *Register*, exhibits the present condition of the profession in Massachusetts.

Counties.	Regular.	Homœ.	Botanic & others.	Total.		Increase.	Decrease.
				1858.	1857.		
Barnstable,	37	1		38	39		1
Berkshire,	71		2	73	73		
Bristol,	90	6	2	98	92	6	
Dukes,	7			7	8		1
Essex,	149	4	8	161	151	10	
Franklin,	43	1	5	49	46	3	
Hampden,	74	2	3	79	72	7	
Hampshire,	50	2	4	56	52	4	
Middlesex (*2 females),	218	6	11*	235	242		7
Nantucket,	5			5	8		3
Norfolk (*3 females),	93	7	5*	105	94	11	
Plymouth (*4 dentists),	57	1	5*	63	50	13	
Suffolk (City, 236 MMS., 102 others; Chelsea, 7), (*25 females),	345		46*	391	396		5
Worcester,	165	5	17	187	186	1	
Total,	1347	35	108	1547	1509	55	17

One physician to $732\frac{135}{1547}$ inhabitants, census of 1855; 1 to $85\frac{1231}{1547}$ aggregate vote of 1857. Increase in the year 1857, 38.

THE BOSTON MEDICAL AND SURGICAL JOURNAL.

BOSTON, APRIL 15, 1858.

MEDICAL SOCIETIES' BY-LAWS AND THEIR INFRINGEMENTS.

We agree with a recently-elected presiding officer of a medical society, in a sentiment expressed by him in his speech on induction into office. He remarked, in substance, that he hoped the proceedings of the Society would be characterized rather by an earnest endeavor for medical improvement, than by tedious and too often wholly useless discussions in reference to the construction and application of the By-Laws. It was well known, he added, that in nearly every association there is at least one man who is "great on the By-Laws," and of whom even "The Autocrat of the Breakfast Table" speaks; indeed, he may have originated the phrase. Much valuable time is often wasted by this individual's (not the Autocrat) pertinacity in regard to the minutiæ of debate, parliamentary usages, &c.

Whilst we believe this to be very often true, it is greatly to be deprecated that too much laxity should prevail, even in medical societies, as to the details of their management. Debate goes on better, and more time is obtained for it, when the proprieties are observed and the regular times assigned for different exercises strictly adhered to. Whenever it is really necessary to depart from this order, no reasonable person will object to a suspension of the rules in the particular instances requiring it; and if the man who is "great on the By-Laws" should interfere under such circumstances, he should be at once put down. A highly esteemed and very judicious medical friend has lately expressed to us rather the opposite opinion to our own. He thinks that a society for medical improvement should always ignore the existence of their by-laws and rules, as far as possible, during their meetings, and that the proceedings should be allowed to go along easily, taking care, pretty much, of themselves. Whilst we respect his learning, value his wise counsel, and are ever ready to defer to his superior knowledge in nearly every particular, we cannot fall in with his views upon this matter; we think much is gained by adherence to the rules of medical, as well as other meetings, and that with a good chairman there need be no stiffness, nor any friction of the machinery.

There is one point upon which we have a few words to say. When by-laws are properly made and passed, and when resolutions of a chartered society are adopted by a vote of its members, the latter are bound, in all honor, we think, no less than by fear of penalty, to respect them, both in spirit and letter. There are more infringements of such obligations by members of the Massachusetts Medical Society, in good standing, than they, or the Society as a body, would be willing to acknowledge. In our issue of February 25th, 1858, a series of resolutions, set forth and adopted by the Councillors of our State Society, was published. A reference to them will show the earnest endeavor of the Council to prevent all dabbling with "secret remedies" by Fellows of the Society, as well as to express their judgment against all attempts to procure abortion.

With regard to the "secret remedies," we will only allude to one, at this time; and doubtless we shall be told that it is *not*, now, a secret remedy. It is true that the *Peruvian Syrup*, with a hypocritical show of *quasi* ingenuousness, has been announced as the "Protoxide of Iron—combined." We have previously referred to this blundering attempt to dodge the imputation of quackery; the sentence is absurdly incomplete and stupid. It was *known before* that *iron* was the active ingredient—but *with what* is it combined? Aye—there's the rub—here the secresy begins, and the trickery is established; and although we do not imagine that it is combined with anything of consequence, the effort at concealment and mystery which its proprietor thus makes, is enough to preclude its use by honorable physicians.

The first two "Resolutions" of those to which we referred above, read as follows:—

> "*Resolved*, That the Massachusetts Medical Society deem it dishonorable in its Fellows to append their names in any way recommendatory of secret or quack remedies, and any Fellow so exhibiting his name shall be considered as acting in a manner derogatory to the dignity of a Fellow of the Society."
>
> "*Resolved*, That if any physician or chemist, through inadvertence, or misapprehension, shall have been induced to give his recommendation or authority in any way to promote the circulation or sale of any secret or empirical medicine, he shall be expected publicly to disclaim or revoke the same."

We suppose that if a physician writes a prescription, knowing that it will be filled out of a bottle of "secret or empirical medicine," he virtually appends his name to it, lends his influence to its *popular* use, more or less widely, and gives his "recommendation" and "authority to promote its circulation" and "sale." The expectation conveyed in the last resolution, however, will be probably quite as unavailing as the industry and good intentions of the Councillors are, apparently, thrown away. We are cognizant of late and frequent infractions of these resolutions, in the way we have mentioned. Is there no remedy for such an abuse?

FACTITIOUS NOSE.

DR. WILLARD W. CODMAN, dentist, of this city, some time since very skilfully adapted a nose made from porcelain to the face of a young lady who lost the end of her own through the manipulations of a cancer-quack. Whilst in this mutilated state, having been cured of the immediate injury at the Mass. Gen. Hospital, she was seen by an officer of the Institution, who interested himself in her welfare and applied to Dr. Codman in her behalf. She was also retained in the Hospital, and her board paid as a patient during the attempt at reparation of the injured feature. We quote a paragraph from a communication in the *Transcript* of March 5th, over the initials of the gentleman who initiated this charitable project.

> "Dr. Codman took a cast of her face, and, after repeated trials, succeeded at last in making a porcelain nose, to be worn with spectacles. It is of the exact shape of the original organ, and of a color like that of the natural skin. There is nothing in the least repulsive or unsightly about it. Under a common veil, it would not even be noticed. The young girl has gone back to New Hampshire, having derived infinite relief, under what seemed to be a hopeless deformity; and in her behalf, I would bear public testimony alike to the eminent professional ability manifested by Dr. Codman, and to the disinterestedness which led him to offer his services to this poor and comparatively friendless girl, *gratuitously*.
>
> N. I. B."

Quarterly Payments.—We observe from the report of the meeting of the Boston Medical Association, that a resolution was offered by Dr. Bowditch, for adoption by the Association, recommending to members to present their bills for medical attendance quarterly, instead of half-yearly, or yearly, as heretofore. The resolutions were referred to the Standing Committee, who will report upon them at the Annual Meeting in May. We are glad to see this subject brought before the profession, and we hope the Committee will report in favor of the adoption of the resolution. There seems to be no reason why physicians should not be paid every quarter, instead of being obliged to wait, as is too often the case, a whole year, or even longer, for money which is justly due them. Now that the system of long credits is being abolished, it is more necessary than ever to have the means of paying our own quarterly bills. If physicians' bills had hitherto been paid quarterly, as a rule, a large amount would have been saved to them during the past year, which was utterly lost. How many people of wealth who could have paid with ease their doctors' bills on the first of July, lost all their property before the first of January.

Suffolk District Medical Society.—At the Annual Meeting of this Society, held Wednesday, April 7th, the following officers were elected: *President*, A. A. Gould; *Vice President*, C. G. Putnam; *Secretary*, C. D. Homans; *Treasurer*, A. A. Watson; *Librarian*, R. M. Hodges; *Supervisors*, M. S. Perry, A. B. Hall; *Commissioner on Trials*, E. Buck; *Councillors*, J. Bigelow, G. Hayward, E. Buck, J. Ware, J. Homans, J. Jeffries, W. Lewis, D. H. Storer, J. Flint, C. G. Putnam, H. G. Clark, H. I. Bowditch, J. M. Warren, S. Durkee, H. Dyer, A. A. Watson, A. A. Gould, E. Palmer, Jr., G. Bartlett, M. S. Perry, J. B. S. Jackson, N. B. Shurtleff, C. Gordon, J. B. Forsyth (*Chelsea*), C. E. Ware, P. M. Crane, W. J. Dale, J. Ayer, W. E. Coale, S. Cabot, H. J. Bigelow, J. B. Alley; *Censors*, W. W. Morland, H. W. Williams, W. E. Coale, C. E. Ware, Francis Minot.

Health of the City.—The mortality of the past week is quite small. The most fatal diseases, after consumption, were pneumonia and scarlatina. The coincidence between the returns and those of the same week of 1857 is striking; thus, the total number for each was 65, the deaths from consumption 14, from apoplexy and croup 2 each. Last week there were 6 deaths from pneumonia and 4 from scarlatina, against 4 and 13 for the corresponding week of last year.

Married,—At Brooklyn, N. Y., 8th inst., J. M. Allen, Jr., M.D., to Miss Eliza Stanton.

Died,—In Worcester, 8th inst., Dr. Oliver H. Blood, 57.—In Blandford, Mass., March 26th, Dr. Silas P. Wright, 62.—At Westport, Conn., April 7th, Joseph Jauncey, M.D., eldest son of the late Dr. Joseph Jauncey, of New York.—In Troy, N. Y., Dr. Avery T. Skilton.—In Philadelphia, April 5th, Dr. John K. Mitchell, long known as a Professor in Jefferson Medical College. Dr. M. was a native of Virginia, but had been for a long time a resident of Philadelphia. He ranked high in the profession.

Deaths in Boston for the week ending Saturday noon, April 10th, 65. Males, 37—Females, 28.—Accident, 1—apoplexy, 2—asthma, 1—bronchitis, 1—congestion of the brain, 1—disease of the brain, 3—consumption, 14—convulsions, 1—croup, 2—dysentery, 1—dropsy, 2—dropsy in the head, 5—debility, 1—infantile diseases, 3—puerperal diseases, 1—scarlet fever, 4—typhoid fever, 1—disease of the heart, 2—inflammation of the lungs, 6—congestion of the lungs, 1—disease of the liver, 1—marasmus, 1—measles, 3—old age, 2—palsy, 3—teething, 1—whooping cough, 1.

Under 5 years, 25—between 5 and 20 years, 9—between 20 and 40 years, 18—between 40 and 60 years, 5—above 60 years, 8. Born in the United States, 47—Ireland, 16—other places, 2.

Buffalo Medical College.—The Annual Commencement of this College took place on the 23d of February. Ex-President Fillmore, Chancellor of the University of Buffalo, conferred the medical degree on nine young gentlemen. The distinction of special mention in regard to particularly meritorious theses was conferred by the faculty on five gentlemen; and the honor of an authority to publish, on two of these. The charge to the graduates was given by Prof. Moore, of Rochester. The following brief extract from a notice of it, in the Buffalo Medical Journal, will convey some idea of the subject and style of a portion of the charge:—"To the physician, however, to his pocket and fame, drugs are the amulet which is indispensable. The physician who gives advice is, by the masses, rejected for him who gives physic. The people have no appreciation of the silent forces of nature, and how gently and easily they may be guided by the skill of the acute, investigating physician. They wish physic, pills, boluses and potions, big or little, and as long as the appetite exists they will have them."

Jefferson Medical College, Philadelphia.—At a public commencement, held March 9th, the degree of Doctor of Medicine was conferred on 209 graduates of this school. The usual charge was delivered by Prof. Charles D. Meigs.

Medical College of Ohio.—Commencement at Cincinnati, March 2d, when the degree of M.D. was conferred on 43 graduates. Address to the class by the President of the Board of Trustees, Hon. J. P. Foote.

Nashville Medical School.—The number of students attending the late session of lectures of the Medical Department of the University of Nashville, was 353. Of these, 109, having complied with all the requisitions of the University, were proposed by the faculty for the degree of Doctor of Medicine, which was accordingly conferred upon them.

Medical College of the University of Michigan.—The exercises at the Annual Commencement of this school, at Detroit, took place March 20th, on which occasion 27 gentlemen received the degree of Doctor of Medicine. The address was by Dr. J. H. Beech, of Coldwater.

Number of graduates, this season, in the Medical College of Georgia, 61; University of Pennsylvania, 145; Oglethorpe Medical College, 11; Pennsylvania Medical College, 35.

Mortality in New Orleans for the Year 1857.—Whites, of both sexes, 6,067; colored, of both sexes, 1,096. By cholera, 29; yellow fever, 199; scarlet fever, 86; trismus nascentium, 199; consumption, 661. To these may be added—stillborn, 398. According to the report of the President of the Board of Health, three-fourths of the stillborn, and three-fifths of the trismus cases, occur in the hands of the ignorant midwives. Subtract, then, as unnecessary deaths, half the still-born and half the trismus cases (in all amounting to 298); and then deduct one half the consumption cases, as being deaths occurring amongst persons who have contracted the disease elsewhere, and who really come here only to die (being 330), and we have a total of 628 to deduct from the total mortality of 6,067—thus leaving us something like a fair total mortality of 5,439 for the past year. Assuming our population, then, to be about 170,000 (and this is thought to be a very fair estimate), and we have a mortality of about one in every thirty-one of the inhabitants.—*N. O. Medical News and Hospital Gaz.*

Missouri State Lunatic Asylum.—From Fulton, we learn that the State Lunatic Asylum is crowded to its utmost capacity, containing one hundred and sixty inmates. The condition of the patients, so far as general health and comfort are concerned, is most favorable. The Institution is in good hands, and is a credit to the State.—*St. Louis Med. and Surg. Journal.*

Novel Importation.—Among the cargo of the Dane steamer, discharging in the Southampton docks on Saturday, from the Cape of Good Hope, were seven cases, addressed to Dr. Schwarz, Germany. The contents being unknown, they were taken to the "sight floor" for examination by the Customs' officers, when they were found to contain various specimens of natural history. One case was filled with human bones, and in another case were four tins, each containing the head of a negro, preserved in brandy in a jar closely secured in the tin. The whole were in the most perfect condition.—*London Times.*